Hawaii Dept. of Health, Office of Health Care Assurance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125046	A. BUILDING: _____ B. WING _____	10/19/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PU'UWAI 'O MAKAHA	84-390 JADE STREET WAIANAE, HI 96792

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4 000	Initial Comments A state re-licensure survey was conducted at the facility from 10/16/2018 - 10/19/2018. The facility's census was 77 residents at the time of entrance.	4 000		
4 105	11-94.1-22(g) Medical record system (g) All entries in a resident's record shall be: (1) Accurate and complete; (2) Legible and typed or written in black or blue ink; (3) Dated; (4) Authenticated by signature and title of the individual making the entry; and (5) Written completely without the use of abbreviations except for those abbreviations approved by a medical consultant or the medical doctor. This Statute is not met as evidenced by: Based on observation, electronic medical record (EMR) review and staff interview the facility failed to document an identified skin tear resident (Resident (R) 61) acquired after it occurred on 10/10/18. This deficient practice had the potential to affect the remaining residents at the facility who are at risk for skin breakdown if they develop a skin tear and this is not accurately documented to reflect the resident's skin condition. Findings Include:	4 105	1. RCM who identified skin tear documented a late entry in resident #61 record on 10/19/18. 2. Orders were reviewed for previous 30 days (10/19/18). Any resident with skin related treatments had their records reviewed for correlating documentation. 3. Current process for capturing skin issues will be reviewed and updated as indicated to ensure proper documentation on skin issues. LN were in-serviced on 11/26/18 regarding proper skin	12/3/18

Office of Health Care Assurance
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 11/19/18

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4 105	Continued From page 1 On 10/18/18 at 12:11 PM observed dressing change to R61's right coccyx/buttock area which appeared to be a stage 2 pressure ulcer (PU). Inquired of Registered Nurse (RN) 4, who did dressing change, what R61's pressure ulcer was staged at and she stated the Resident Care Manger (RCM) 1 stated that it was a "skin tear" not a pressure ulcer. On 10/18/18 at 12:14 PM interviewed RCM1 who stated the area on R61's coccyx had a small skin tear with a flap. RCM1 explained the area with the flap healed and the open areas were from the skin tear. Noted upon observation R61 appeared to be placed more on his back in bed and inquired RCM1 about this and she stated R61 is on a turning cycle. RCM1 explained there are no set times but it is routine to turn R61 every two hours. RCM1 explained staff turn R61 from his side to his back and then to his other side. On 10/18/18 at 12:23 PM interviewed Certified Nurse Assistant (CNA) 2 and CNA3, who stated R61 is turned every two hours side to side and they used a wedge to keep R61 from going onto his back. Wedge appeared soft but firm enough to keep R61 in position and was placed under the sheet under R61's upper back and did not touch his right coccyx/buttock area. CNAs stated they keep R61 off of his back. The use of the wedge did not appear to cause any injury to R61. On 10/19/18 at 08:53 AM interviewed RCM1 and requested documentation of skin tear R61 acquired on 10/10/18. RCM1 stated she and the nurse practitioner (NP) went that day (10/10/18), after it was found, to see R61's wound and decided on the treatment. RCM1 did a review of R61's electronic medical record (EMR) and found the NP wrote a progress note on 09/26/18 but did	4 105	documentation protocols. 4. Audits will be conducted monthly until substantial compliance is met. QAA committee will review to determine continuation and frequency of audits. Responsible Party: DON or designee	

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4 105	Continued From page 2	4 105		

not document a skin tear on 10/10/18. Inquired of RCM1 for a copy of any progress note documenting the skin tear that was discovered and reported and RCM1 stated she reviewed the progress notes but there was no documentation of the skin tear by the nurse assigned to work with R61 on 10/10/18, and no documentation by herself and the NP who observed the wound on 10/10/18. Further electronic medical record (EMR) review for R61 found there was no documentation of this wound under the Wounds tab. RCM1 checked the staffing schedule and explained the assigned nurse working with R61 on 10/10/18 was a new nurse who had just come off of orientation and also stated that she was not making excuses but trying to find why this occurred. When inquired RCM1 admitted she and NP did not document the skin tear which they should have.

On 10/19/18 at 12:50 PM interviewed and did record review of R61's EMR with Director of Nursing (DON) who confirmed he could not find any progress notes that mentioned a skin tear on R61's right coccyx/buttock area from 10/10/18. Reviewed R61's progress notes and found there was no mention of a skin tear to R61's coccyx/buttock area till 10/19/18 with a late entry put into R61's EMR by RCM1. Noted the progress note stated the skin tear was on R61's left coccyx/buttock area. Escorted by DON to interview RCM1 regarding the late entry progress note she wrote in R61's EMR. Prior to meeting with RCM1 confirmed with RN4 dressing change observed on 10/18/18 was to R61's right coccyx/buttock area. Inquired of RCM1 which side the R61's skin tear occurred and she stated it was the left side and when told the dressing observation was for R61's right side RCM1 stated it was an error on her part, with the progress note

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4 105	Continued From page 3 she wrote and that she would fix it, that she was busy. On 10/19/18 at 01:06 PM RN corporate trainer showed surveyor the discovery of R61's skin tear was logged in the physician's communication book and was dated 10/10/18. Overall it was noted R61's right bottom/coccyx area appeared to have an old scar with very fragile skin that was healing from a reported skin tear which staff appear to be taking care of. The deficient practice did not accurately document the finding of the skin tear and did not accurately reflect R61's skin condition of healing open areas from the skin tear located on R61's right coccyx/buttock area.	4 105		
4 153	11-94.1-40(a) Dietary services (a) The food and nutritional needs of the residents shall be met through a nourishing, well-balanced diet in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, and shall be adjusted for age, sex, activity, and disability. (1) At least three meals shall be served daily at regular times with not more than a fourteen hour span between a substantial evening meal and breakfast on the following day; (2) Between meals nourishment that is consistent with the resident's needs shall be offered routinely and shall include a regular schedule of hydration to meet each resident's needs;	4 153		12/3/18

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4 153	Continued From page 4 (3) Appropriate substitution of foods shall be promptly offered to all residents as necessary; (4) Food shall be served in a form consistent with the needs of the resident and the resident's ability to consume it; (5) Food shall be served with appropriate utensils; (6) Residents needing special equipment, implements, or utensils to assist them when eating shall have the items provided by the facility; and (7) There shall be a sufficient number of competent personnel to fulfill the food and nutrition needs of residents. Paid feeding attendants shall be trained as per the facility's state-approved training protocol. This Statute is not met as evidenced by: Based on observations, resident and staff interviews, and electronic medical record (EMR) reviews, the facility failed to ensure that a baseline care plan (CP) was developed within 48 hours for one of 38 residents (Resident (R) 321) sampled for review, included the instructions needed to provide effective and person-centered care that met professional standards of quality care for a blind resident. Findings Include: On 10/16/18 at 01:19 PM interviewed R321 who was admitted on 10/15/2018 and the resident stated he was admitted to the facility because of being blind and had bilateral lower extremities amputated, (left below knee amputee [BKA] and	4 153	1. Care plan was updated on 10/18/18 regarding set up of food (Place food in bowls to assist with eating explain to him what he is being served, where location of food is ensure hands are cleansed prior to meal as he may tend to grab food with hands) for resident #321 who is blind. Kardex (care plan) was already in place at time of observation. 2. An audit of care plans for visually impaired residents who require tray set up that can feed self was conducted on 11/6/18. Based on audit results no follow up was needed. 3. Nurse Management Team were re-educated on 11/15/18 regarding the requirements of a baseline care plan to	

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4 153	Continued From page 5 right above knee amputee [AKA]). R321 stated he had "constitutional rights" to live freely and not be institutionalized, as he lived in institutions most of his life. The resident stated he wanted to do things for himself as much as possible and wanted to be independent. Queried R321 if he participated in admission and/or care plan goals, and R321 stated he was upset about being placed at the facility and had no choice in the decision-making. Further inquired how R321 ate at the facility and whether the food served was to his liking. The resident stated being blind he used his hands to eat, because he was unable to see food on the plate to poke with a fork, and the food would just slip off the plate. Inquired if R321 always ate with his hands and R321 stated at home he ate with a bowl and spoon because he knew how to scoop from the sides of the bowl. The resident further stated the food served at the facility was good but preferred dry food to eat with his hands as it would be difficult to eat wet, oily/gravy foods using his hands. Walked pass R321's room on 10/18/18 at 12:15 PM and overheard R321 yelling at the Certified Nurse Assistant (CNA) setting-up his lunch tray. The resident was very upset and used foul language so stopped to observe from the doorway. The CNA had just placed the lunch tray down and said, "This is your lunch." The resident responded, "You guys all stupid, how I supposed to know where the cup or plate, I blind, I cannot see." The CNA directed R321 to the cup of coffee and plate as he felt around the lunch tray with his fingers, continuing to verbally abuse the CNA with foul language. The CNA apologized to R321 and continued to direct him to the placement of the plate of food and coffee cup on	4 153	meet person centered standards of quality of care for blind residents. 4. Audits will be conducted monthly until substantial compliance is met. QAA committee will review to determine continuation and frequency of audits. Responsible Party: DON or designee	

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4 153	Continued From page 6 the tray. On 10/18/18 at 04:00 PM interviewed the Director of Nursing (DON) and inquired about the 48 hour baseline CP for R321. DON found on R321's EMR that RN3 did the nursing admission evaluation on 10/15/18 at 03:45 PM, and documented the resident had impaired vision under the communication paragraph. Inquired of the DON if being blind is the same as having impaired vision. The DON stated that the nurse should have noted the resident as being blind because impaired vision can usually be corrected with prescription lenses. Inquired of the DON if facility staff considered how R321 ate, as the resident is blind, and shared observations of R321 being served lunch. DON stated he would investigate. The DON provided R321's baseline CP developed on 10/16/2018 that included, "Nutrition Altered," with goal to achieve desired weight /nutrition; but, there was no baseline CP to indicate that R321 was blind and how activities of daily living such as eating would be performed. The DON stated R321 was to be transferred to the facility at an earlier date (10/10/18) but R321 delayed the process and was provided a State court appointed guardian for admission to the facility on 10/15/2018. The facility failed to complete and implement a baseline CP within 48 hours of R321's admission to promote continuity of care and communication among staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission; and to ensure the blind resident, was informed of the initial plan for delivery of care and services by the facility.	4 153		

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4 172	11-94.1-42(j) Physician services (j) Each resident shall receive age-appropriate immunizations or vaccinations including but not limited to pneumococcal and annual influenza vaccines and any necessary immunizations following the recommendations of the Advisory Committee of Immunization Practices unless otherwise contraindicated, or refused by the resident, legal guardian, or surrogate. All immunizations provided shall be documented in each resident's medical record. This Statute is not met as evidenced by: Based on electronic medical record (EMR) review and interview, the facility failed to administer the pneumococcal immunization to one of five sampled residents (Resident (R) 2) who was eligible to receive the vaccine. This deficient practice placed R2 at risk for acquiring pneumonia. This deficient practice had the potential to affect the remaining 72 residents at the facility if they were not screened, offered and given the pneumococcal vaccine. Findings Include: A review of R2's EMR found there was no documentation a pneumococcal immunization had been given, declined or contraindicated. Review of R2's last quarterly Minimum Data Set (MDS) dated 07/09/18 found R2 is a 94 year old female resident with a diagnosis of dementia. On 10/18/2018 at 02:35 PM, an interview was conducted with the Director of Nursing (DON), who stated "R2's consent forms were marked 'No' from 2007-2013", indicating the pneumococcal immunization was declined. "In 2014 the status of R2 was updated, and a legal representation was	4 172	1. Resident #2 was administered her pneumococcal vaccination on 10/19/18. 2. Residents who consented for the pneumococcal vaccine were audited for administration of the vaccine and follow up was conducted as needed. 3. Vaccination consent process was reviewed, and licensed nurses were in-serviced on 11/26/18 on timely administration of pneumococcal vaccinations and utilization of the vaccination record. 4. Audits will be conducted monthly until substantial compliance is met. QAA committee will review to determine continuation and frequency of audits. Responsible Party: DON or designee	12/3/18

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4 172	Continued From page 8 appointed through the Office of Public Guardianship (OPG). The OPG returned the Vaccine Consent/Declination form marked 'yes' consenting for R2 to receive the pneumococcal immunization." The DON provided a copy of the Vaccine Consent/declination form dated "3/03/18", and confirmed the vaccine had not been given. Reviewed the facility policy titled "Immunizations: Pneumococcal Vaccination (PPV) of Residents/Guest" and found the facility did not follow their facility guidelines. This policy stated "The Advisory Committee on Immunization Practices (ACIP) recommends vaccinating persons at high risk for serious complications from pneumococcal pneumonia, including those 65 years and older and all resident/guests of nursing homes. Recognizing the major impact and mortality of pneumococcal disease on resident/guests of nursing homes and the effectiveness of vaccines in reducing healthcare costs and preventing illness, hospitalization and death, this community has adopted the following policy statements: A. All resident/guests of our community should receive the pneumococcal vaccine if they are 65 years of age or older or younger than 65 years with underlying conditions ..."	4 172		
4 192	11-94.1-46(i) Pharmaceutical services (i) Appropriately licensed and trained staff shall be responsible for the entire act of medication administration, which entails removing an individual dose from a container properly labeled by a pharmacist or manufacturer (unit dose included), verifying the dosage with the physician's orders, giving the specified dose to	4 192		12/3/18

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4 192	Continued From page 9 the proper resident, and promptly recording the time, route, and dose given to the resident, and signing the record. Only a licensed nurse, physician, or other individual to whom the licensed professional has delegated the responsibility pursuant to chapter 16-89, subchapter 15, may administer medications. This Statute is not met as evidenced by: Based on observations and staff interviews, the facility failed to ensure staff were qualified to administer medications to two of 38 residents (Residents (R) 4, R19) sampled for review. The facility permitted unlicensed personnel to administer medications crushed and mixed in liquid or pudding. This is beyond the scope of practice for a Certified Nurse Assistant (CNA), is unsafe, and does not meet current standards of practice. This deficient practice had the potential to affect those residents at the facility who required their medications to be crushed and administered to them if they were given their medication(s) in a similar manner by unlicensed staff. Findings Include: 1) On 10/17/18 at 08:21 AM, observed the CNA as she prepped and set-up R4 for breakfast. R4 was bed bound due to her diagnosis of Huntington's Chorea and slept on mattresses that were placed directly on the floor. The CNA had to sit on the mattress to feed R4 and Licensed Practical Nurse (LPN) 1 walked into R4's room with a medicine cup of crushed medications, stood next to the mattress and asked the CNA where she wanted the crushed medications poured into as the CNA fed R4 breakfast. The	4 192	1. Identified Staff were in serviced on proper med pass practices on 10/19/18. 2. An audit of licensed nurse med pass practices was conducted, and proper follow-up initiated on 10/19/18. 3. Current med pass protocols have been reviewed for appropriateness. In-servicing on current processes was completed on 11/29/18 regarding med pass practices with nursing staff. 4. Audits will be conducted monthly until substantial compliance is met. QAA committee will review to determine continuation and frequency of audits. Responsible Party: DON or designee	

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4 192	Continued From page 10 CNA opened a chocolate pudding cup, LPN1 poured the crushed medications into the pudding cup and walked out of the room. Observed as the CNA mixed the crushed meds into the pudding cup and provided a spoonful of pudding to R4. Inquired of the CNA if R4 usually ate all of the pudding, and the CNA replied that chocolate pudding is R4's favorite, and rotated between spoonfuls of pureed breakfast meats and pudding. LPN1 continued with medication administration to other residents on the unit. Inquired of LPN1 if crushed medications administered to R4 were usually done as observed. LPN1 responded, "It says give with food." The Director of Nursing (DON) was at R4's unit nursing station and shared observation of LPN1 pouring crushed medications into the pudding cup and that a CNA fed R4 the medications. The DON stated crushed medications should have been mixed with pudding in med cup and not poured into a pudding cup on the breakfast tray. Inquired if the facility allowed CNAs to administer prescribed medications and responsible for R4 to receive proper medication dose when crushed medications mixed with food. DON stated LPN1 should have administered the crushed medications and not the CNA. On 10/19/18 at 08:36 AM interviewed LPN1 and she stated R4 was prescribed Trazodone 50 mg half tab, (25 mg), Tylenol 325 mg 2 tabs (650 mg), and Mirtazapine 15 mg tab (15 mg); these medications were crushed and combined in the medicine cup that was poured into the cup of pudding on 10/17/2018. According to LPN1, she went back to R4's room to ensure that all of the chocolate pudding was consumed.	4 192		

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4 192	Continued From page 11 The facility did not ensure that prescribed medications were provided by individuals with proper licensure, skills and experience. 2) Review of R19's Medication Administration Record (MAR) and Clinical Notes dated 09/15/18 indicated the 07:00 AM dose of Senna Plus (laxative), and aripiprazole (antipsychotic) was prepared and signed off as "administered" on the MAR at 06:18 AM by the night shift Registered Nurse (RN) 1. At 08:39 AM, the MAR was changed by the day shift RN2 and indicated "not administered" with documentation of "refused to drink her ensure where medication was mixed as res [sic] it taste like spoled [sic]." RN2 documented in the Clinical Note at 08:42 AM, "CNA reported refused to drink her ensure where medication (aripiprazole and senna plus) were mixed." During an interview with Certified Nurse Assistant (CNA) 1 on 10/19/18 at 10:06 AM, she stated "R19 only wants certain people to give the medicine and the CNAs are sometimes asked to give it. R19 only likes certain CNAs." CNA1 explained the medications are crushed and mixed with either orange juice or ensure. When asked if the ensure or orange juice with medications is ever left in the room, she replied "yes." She stated, "Sometimes we are asked by the Charge Nurse to give it. Sometimes we go alone. R29 can drink some by herself, and sometimes we assist." During an interview with Resident Care Manager (RCM) 2, on 10/19/18 at 10:06 AM, the RCM2 stated, "The RN should be in the room and observe the medication is taken, and document that if it is refused. CNAs should not administer	4 192		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
4 192	Continued From page 12 any medications." Interview with RN2 on 10/19/2018 at 10:39 AM stated "Sometimes R19 wants this person to give it. We prepare it if R19 wants specific person, but I always give mine myself. R19's medications were prepared by the night shift and suppose to give. It was already clicked off that it was administered. The CNA picked up the breakfast tray and told me R19 didn't want to finish it. I went back in the record and changed to "not administered" and put "refused." During facility policy review found the facility did not follow the process outlined in their policy titled "Medication Administration General Guidelines". The process includes: 1. "Medications are administered at the time they are prepared." 2. "The person who prepares the dose for administration is the person who administers the dose." 3. "Administer medication and remain with resident while medication is swallowed. Do not leave a medication in a resident's room without orders to do so along with documentation of self-administration", and 4." Chart medication administration on Medication Administration Record immediately following each resident's medication administration."	4 192		
4 197	11-94.1-46(n) Pharmaceutical services (n) Discontinued and outdated prescriptions and containers with worn, illegible, or missing labels shall be disposed of according to facility policy.	4 197		12/3/18

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	125046	A. BUILDING: _____ B. WING _____	10/19/2018

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4 197	Continued From page 13 This Statute is not met as evidenced by: Based on review of medication labels and staff interview the facility failed to ensure medication labels for three of 38 residents (Resident (R) 30, R58 and R65) from the sample list had legible discard dates. The deficient practice had the potential to affect the remaining 74 residents at the facility if their medications were delivered with medication labels that had illegible discard dates and the facility nurse did not identify those. Findings Include: An inspection of a medication cart on Unit one was completed on 10/18/2018 at 11:54 AM. The contracted pharmacy's procedure was to hand write the discard date on the label of medication container/package. Illegible discard dates were found on five of the medication blister packages. Registered Nurse (RN) 2 was present during the inspection and was asked to review the medication label discard dates. RN2 agreed the dates were illegible and unable to determine if these medications were expired. The following labels were illegible for R30 (three blister packs of Diltiazem), R58 (one blister pack of Gabapentin), and R65 (one blister pack Acetaminophen 325 mg tab).	4 197	1. Medications which had illegible discard dates were identified and pharmacy was contacted for replacement on 11/9/18. Pharmacy verified medications were not expired. 2. An audit of medication carts was conducted for any illegible discard dates and pharmacy was contacted for replacement on 11/9/18. 3. Pharmacy staff were in-serviced on writing legible dates on 11/9/18. Process for accepting and returning medications with illegible dates was reviewed and updated as indicated. Licensed nursing staff was educated regarding process on 11/26/18. 4. Audits will be conducted monthly until substantial compliance is met. QAA committee will review to determine continuation and frequency of audits. Responsible Party: DON or designee	
4 222	11-94.1-56(b) Laundry service (b) Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (1) Provisions shall be made for the handling, storage, and transportation of soiled and clean laundry and for satisfactory cleaning procedures;	4 222		12/3/18

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4 222	Continued From page 14 (2) Provisions may be made for contract service outside the facility in a laundry approved by the department; (3) Laundry contaminated with blood, blood products, or infectious waste shall be handled in accordance with U.S. Department of Labor, Occupational Safety and Health Administration (OSHA) regulation 29 C.F.R., Part 1910.1030; (4) Clean linen shall be stored in enclosed areas; and (5) Hampers shall be provided for soiled linen. This Statute is not met as evidenced by: Based on observations and staff interviews the facility failed to ensure that linens and laundry were handled and processed to produce hygienically clean laundry and prevent spread of infection to the extent possible. On 10/19/18 at 01:01 PM observed the facility's laundry room where the washer and dryer units were housed, with a large counter in the center of the room where laundry staffer was folding white sheets. Noted that the windows in the laundry room were open and the air conditioner (AC) units were not on. The window jalousies, screens and counter space below windows were covered in brownish dust-like particles. Used fingertips to wipe off particles and fingertips were covered in brownish substance. Interviewed the housekeeping/laundry director (H/L Dir) 2 who was present in the laundry room and inquired whether window jalousies were left open instead of using air conditioner. The H/L Dir2 stated the AC units were not used because there was no circulation for dryer exhaust and water heater venting if the jalousies were kept	4 222	1. Identified areas were cleaned immediately on 10/19/18. 2. Laundry area was inspected to assure no other deficient areas were identified on 10/19/18. A solid surface divider was installed between the resident care area and laundry sorting area replacing the non-air tight hanging vinyl curtain on 11/16/18. 3. Revised the cleaning schedule of the laundry area. Laundry staff were in-serviced on 11/26/18 on the new process. 4. Audits will be conducted monthly until substantial compliance is met. QAA committee will review to determine continuation and frequency of audits. Responsible Party: EVS Director or designee	

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4 222	Continued From page 15 closed. There were clean linen and laundry stored on rolling laundry carts covered with a red mesh fabric in the laundry room. Dirty linens and laundry were stored and sorted outside of the laundry room on an open-air deck that had a curtain of thick vinyl panels hanging to separate the dirty laundry area from the residents smoking area. The hanging vinyl panels were not air-tight with space between each panel. The facility did not ensure cleanliness and protect clean linen from dust during loading, transport and unloading of clean linens; and, sorting and rinsing of contaminated laundry was done in an adjacent open resident care space.	4 222		
4 243	11-94.1-64(a) Engineering and maintenance (a) The facility shall maintain all essential mechanical, electrical, and resident care equipment in safe operating condition. This Statute is not met as evidenced by: Based on observation, staff interview, and review of facility policy, the facility failed to perform routine maintenance, based on manufacturer's recommendation, and failed to keep preventative maintenance records for six out of six oxygen concentrators reviewed. This deficient practice put the residents at risk for the development and transmission of communicable diseases and infections. Findings Include: During an observation and staff interview, on 10/16/18 at 10:57 AM, with the Maintenance Manager (Maint Mgr) 1. Maint Mgr1 stated the	4 243	1. Oxygen concentrators were checked and cleaned with manufacturer recommendations on 10/3/18. 2. Residents with oxygen concentrators were audited for preventative maintenance and addressed as indicated on 10/3/18. 3. Environmental Services were re-educated on 11/23/18 on the preventative maintenance schedule of concentrators and method to clean in accordance with manufactures requirements. 4. Audits will be conducted monthly until substantial compliance is met. QAA committee will review to determine	12/3/18

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4 243	Continued From page 16 cleaning of all Oxygen Concentrator Filters were supposed to be done on a weekly basis. Maint Mgr1 said prior to 10/03/18 the process to clean and maintain the filters were not in place and not being done. It was only on 10/03/18 when the facility began the process to properly clean and maintain the filters. A review of facility policy on Maintenance Service revealed a section which stated "Maintenance personnel shall follow the manufacturer's recommended maintenance schedule." Another section stated "The Maintenance Director or designee is responsible for maintaining the following records/reports ... Maintenance schedules." This was not being followed. A review of the Service manual for the AirSep NewLife Intensity Oxygen Concentrator revealed a section (4.2) on Cleaning and Infection Control which stated "Clean the air inlet gross particle filter with warm soapy water between each patient's use. Clean this filter at least once per week, depending on the environment, during normal operation." This also was not being followed. Another review of the Service Manual for the AirSep NewLife Elite Oxygen Concentrator revealed a section (3.2) on Cleaning the Air Intake Gross Particle Filter which stated the patient/facility must clean this filter weekly. The filter may require daily cleaning if the unit operated in a harsh environment ... During an interview with the Maint Mgr 1, on 10/19/18 at 2:00 PM, Maint Mgr 1 presented a maintenance log that was created for various items which included the Oxygen Concentrators. Maint Mgr 1 also stated the process to properly	4 243	continuation and frequency of audits. Responsible Party: EVS Director or designee	

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4 243	Continued From page 17 clean and maintain the Oxygen Concentrators was currently in place and being followed.	4 243		